EXHIBIT

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August 25, 2010

Law Firm of Joseph A. Massood
Andrew R. Bronsnick, Esq.
50 Packanack Lake Road East
Wayne, NJ 07470

Re: Mark Stevens
Date of Birth: 7/21/70
Date of Incident: 3/24/07

Dear Mr. Bronsnick:

Please find enclosed a medical report in narrative form indicating the dates of treatment as well as type, my diagnosis and prognosis of Mark Stevens.

HISTORY: Mr. Stevens was first seen by me in my office on 8/29/07 and he gave the following history. He presented with right knee pain. He claimed that the condition started on 3/24/07 when he was allegedly assaulted and slammed to ground injuring his right knee. He was initially seen in the hospital at Beth Israel Medical Center, Newark in the emergency room but, because of persistent complaints and problems in the knee causing chronic pressure and swelling, he eventually underwent an MRI test allegedly ordered by his family doctor. This test was completed on 8/15/07. He works every day as a bus driver, picking up and dropping off passengers for New Jersey Transit. He denied any other type of significant medical problems.

A complete orthopaedic examination was performed on that date with the following findings. He was a well-developed, well-nourished male looking his stated age. He presented with a chief complaint of pain into the right knee area. The knee was examined and alignment was normal. He had a slight antalgic gait with a slight limp. There were no scars or discolorations and no ecchymosis present on this particular day, 8/29/07. A mild effusion was present. He was unable to squat secondary to the pain into the posterior aspect in the medial portion of his right knee joint. He was unable to fully flex. Medial joint line pain was present with palpation, posteriorly, and he had positive McMurray and positive Apley tests, medially and posteriorly. No gross instability was present. The cruciate and collateral ligament testing appeared to be intact.

An MRI of the knee joint was reviewed and revealed a vertical tear in the posterior horn and medial meniscus with a tiny joint effusion. No other evidence of problems was detected. All of this was discussed with the patient. A recommendation for treatment was made.

I explained to the patient that in my opinion because of the persistence of the problems for such a long period of time that surgery was probably indicated based on these findings and his failure to respond to any type of care to date. He was seen again on 11/26/10. He remained with persistent complaints. Again, because of the failure to respond, surgery was offered. All of the risks, benefits and expectations of the surgical procedure were explained to the patient. He had his surgery completed on 11/30/07 and the diagnosis was a tear of the medial meniscus, posterior horn, and an arthroscopic medial meniscectomy was performed. He was then followed up on a serial basis postoperatively. He was seen on 12/10/07. He was handling his pain very poorly, using crutches. I discussed an appropriate exercise program. Another postoperative booklet was given with all of the explanations of the postoperative regimen in place. He was seen on 12/17/07 and still had some complaints of pain but no fever, chills, etc.

His compliance had been poor to date. We recommended supervised physical therapy, as he was not able to comply with the appropriate postoperative care. He was placed in a physical therapy program. On follow-up of 1/7/08, he was doing much better. He was attending physical therapy and was only using one crutch. He claimed episodes of swelling but his knee looked quite good. The wounds were clean and dry. There was very mild swelling and no atrophy. He was placed in an exercise program in an effort to rid him of the crutches and improve strength. He was seen on 2/4/08. The knee showed mild effusion but much improved. He was ambulating without the use of aides. He was attending physical therapy on a regular basis and, again, in my opinion he was to continue with the quad and hamstring exercise programs under supervision. Light duty status was allowed. On 3/3/08, he was seen again with continued improvement. He was seen on 5/21/08, status post surgery. He was doing quite well without any significant problems at that point in time. He was seen on 6/18/08. He was doing much better but the vastus medialis obliquus still had some atrophy present and he still needed supervised physical therapy. He continued to be prescribed the therapy. He was lost to follow-up until 11/26/08. He complained of right knee pain. He said he was unable to run. There was decreased flexion of the knee. He noted a decrease in the ability to do some physical activities. On physical examination, he ambulated with a normal gait. He had flexion to about 90 degrees. He was fully able to extend his knee. He had decreased bulk, status post right knee quad insufficiency and decreased flexion. He was recommended to return to physical therapy under supervision. He was seen on 3/6/09. He had some help with physical therapy which was performed in November 2008 and the prescription was completed. He still had some residual symptoms, mainly weakness and pain. He was to renew physical therapy and follow-up in a month. On 4/29/09, he was seen again attempting with physical therapy. He thought he needed to stay out of work to go full time to physical therapy. He was placed on physical therapy. He was seen on 6/15/09. He had been attending physical therapy at Beth Israel Hospital. I received no progress report. I instructed him to mention this to the therapist. I had no expectations of being able to judge how well he was doing and whether he was attending on an appropriate basis. Overall, there was some improvement in strength. He was to continue with supervised physical therapy and follow-up in four weeks' time. He was seen on 7/13/09 as well as being seen on 8/17/09. He recently had some personal problems at home. Physical therapy had been completed and he did okay with it. He was last seen again with a return to work status on 9/1/09 with no restrictions.

The patient sustained a tear, if the story is correct and true, to his medial meniscus of his right knee secondary to an altercation. He eventually underwent surgical intervention as well as a prolonged physical therapy program under supervision. He was returned to work on 9/1/09 without restrictions. He lost meniscal material, and postoperative traumatic arthritis may develop over time. This is a permanent sequelae.

Sincerely,

Thomas F. Cuomo, M.D.

TFC/eag